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CLARIFICATION OF COPAY ISSUES

DMS provides the following information to clarify questions from providers regarding copay for recipients who have a ME code 74, 75, 76, 77, or 79.

Pharmacy Services

- Copay only applies to pharmacy claims billed by a pharmacy provider (provider type "60"). Copay does not apply to pharmacy claims billed by a physician or other practitioner using a provider number other than provider type "60." For example, a physician with a provider type "20" may bill on a pharmacy claim form; however, DMS will not deduct copay from the reimbursement of the drug. DMS does not require providers, other than pharmacy to collect a copay for drugs that are dispensed and billed to Medicaid.

- The normal pharmacy shared dispensing fee exemptions *do not* apply to ME codes 76, 77, and 79. DMS requires uninsured working parents to pay a $5.00 pharmacy copay ***and*** the shared dispensing fee of $0.50-$2.00. The recipient *must* pay both the copay and the shared dispensing fee amount even if the drug is: for family planning; pregnancy related; or for an emergency. *The provider must provide the service even if the recipient does not pay the copay or the shared dispensing fee.*

- Children with a ME code 75 do not pay the shared dispensing fee for any drugs. They pay only the $5.00 pharmacy copay.

- If the usual and customary amount plus the shared dispensing fee is less than the $5.00 copay to be charged to the recipient, the provider should charge the lesser amount of the shared dispensing fee plus the usual and customary amount. For example, if the total of the usual and customary amount for a drug ($4.25) plus the shared dispensing fee (.50) equals $4.75, the provider should only charge the recipient $4.75 because the total is less than the copay amount of $5.00. *Do not* charge the recipient $5.00 or $5.50. If the usual and customary amount is $5.00 or more, the provider should charge the copay and shared dispensing fee.

Outpatient Services

- There are no exemptions to the copay requirement for outpatient or emergency room services.

- DMS will not deduct the copay on the professional provider's services for procedures requiring a copay when the POS is 21 (inpatient), 22 (outpatient), 23 (emergency room), 24 (ambulatory surgical center), 51 (inpatient psychiatric facility), 61 (comprehensive inpatient rehab facility), and 62 (comprehensive outpatient rehab facility).

- DMS only requires a recipient to pay a copay amount to the inpatient hospital, outpatient facility when seen in an outpatient or emergency room (if the hospital bills a facility charge code), or when the Ambulatory Surgical Center (ASC) charges the copay. *The professional provider should not charge a copay also when services are provided in these settings.*

- A podiatrist does not charge a copay when the W2 modifier is used to show the service was an outpatient visit.

- When a practitioner administers a vaccine (other than VFC) or other pharmacy product in the office and bills for the product on a pharmacy claim form, the practitioner does not charge the $5.00 copay or the dispensing fee for the drug. When it applies, the practitioner charges only the copay for the office visit.

- Individual office visits for prenatal care are *not* exempt from the copay requirement.

NOTE: Providers should encourage pregnant women with a ME code of 71, 72, 73, 74, 75, 76, 77, 78, 79, or 80 to apply for regular MC+/Medicaid. The advantage to the woman is the elimination of the copay requirement and receipt of more services including Non Emergency Medical Transportation (NEMT). The advantage to the provider is that under regular MC+/Medicaid the provider does not collect copay, nor is copay deducted from the reimbursement amount of the claim.

- The provider should collect only one copay amount when they furnish more than one service requiring a copay at a single office visit on the date of service.

- When the Medicaid Maximum Allowed Amount for an office visit is equal to or less than the copay amount, the provider should charge the lesser amount of the Maximum Allowed Amount or the copay. For example, the Medicaid Maximum Allowed Amount for procedure code 99211 equals $5.00; therefore, the provider should charge the recipient with an ME code 74 a $5.00 copay. The provider should only charge $5.00 to recipients with ME codes 75, 76, 77, and 79 instead of $10.00 because the Medicaid Maximum Allowed Amount is less than the copay amount of $10.00. In either case, the Medicaid Maximum Allowed Amount is reduced by the copay amount and the reimbursed amount would be zero.

- Special Bulletin Vol. 21, No. 4 dated January 22, 1999, pages 4 and 5 states DMS only covers dental and optical care for uninsured working parents when related to trauma or disease. Medical or surgical services are covered for ME codes 76, 77, 78, and 79; however, the supporting dental or optical care is only covered when required because of trauma or disease. DMS does not cover dental or optical care for uninsured working parents in absence of medical or surgical procedures. This is to announce that:

  - *A dental provider may bill an office visit (requires copay) and x-rays (when indicated) when he or she sees an uninsured working parent to decide whether they need dental care related to trauma or disease.*

    Note: The following dental x-rays are allowed when trying to determine if the recipient's problem is the result of trauma or disease: D0210, D0210W5, D0220, D0230, D0290, and D0330.

  - *An optical provider may bill an office visit (requires copay) when he or she sees an uninsured working parent to decide whether they need optical care related to trauma or disease.*

    NOTE: Unless the provider is a physician, only an optometrist provider type 31 (specialty 82 {Certified Optometrist}) or optometry clinic (performing provider type 31) may bill an office visit to determine trauma or disease.

  If it is discovered at the office visit that the patient's need for dental or optical services *is not* due to trauma or disease, a treatment plan *should not* be initiated unless the patient agrees in writing to be a private pay patient.

CORRECTIONS

- Special Bulletin Vol. 21, No. 1 dated September 11, 1998, stated, children with ME codes 74 and 75 are required to pay a $10.00 copay for inpatient services. This is incorrect. There is **NO** copay for inpatient services for uninsured children in an inpatient setting.

- Special Bulletin Vol. 21, No. 4 dated January 22, 1999, page 7 shows provider type 33 and 34 must charge a copay for ME codes 76, 77, and 79 for procedure code 92506. This is incorrect. The procedure is covered as an HCY service only. Uninsured working parents are not eligible for the service; therefore, copay would not apply.

- Special Bulletin Vol. 21, No. 4 dated January 22, 1999, page 6 shows procedure codes Y4000 and Y4001 covered for TOS 1 and B. This is incorrect. These procedure codes are only covered for TOS B.

- Special Bulletin Vol. 21, No. 4 dated January 22, 1999, page 6 states a copay is applicable to dental claims with TOS 7 office visits. System programing does not currently allow office visits for TOS 7 to be reimbursed for ME codes 09 (General Relief) or ME codes 76 through 79 (Uninsured Working Parents). The provider does not need to bill the office visit codes or x-ray codes under the dump code 41899. The Division of Medical Services will adjust and reimburse denied office visit and x-ray claims upon completion of system updates.

FAMILY PLANNING PROCEDURES FOR ME CODE 80

The following information replaces the Family Planning Procedure Codes listed on page 10 of Special Bulletin Vol. 21, No. 4, dated January 22, 1999.

The only procedures covered for ME code "80" beyond Evaluation and Management office visit codes are:

PROCEDURE CODE	DESCRIPTION
A9195*	Medical and surgical supplies (IUD/Diaphragm/Cervical Caps only)
J1055**	Injection of Medroxyprogesterone Acetate for contraceptive use, 150 mg
Z2082**	Levonorgestrel (Norplant)
11975	Insertion, implantable contraceptive capsules (Norplant)
11975W1***	Insertion, implantable contraceptive capsules (Norplant)
11976	Removal, implantable contraceptive capsules (Norplant)
11977	Removal with reinsertion, implantable contraceptive capsules (Norplant)
11977W1***	Removal with reinsertion, implantable contraceptive capsules (Norplant)
56301	Laparoscopy with fulguration of oviducts
56302	Laparoscopy with occlusion of oviducts by device
58300	Insertion of intrauterine device (IUD)
58600	Ligation or transection of fallopian tubes
58605	Ligation or transection of fallopian tubes, postpartum
58611	Ligation or transection of fallopian tubes, when done at time of C-Section
58615	Occlusion of fallopian tubes by device
99070	Supplies and material provided by the practitioner over and above those usually included in the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

* The fitting of a diaphragm/cervical cap or the removal of an IUD is included in the fee for an Evaluation and Management (E/M) procedure code. (Invoice required for the supply).

** Procedure codes J1055 and Z2082 are only billable by an RHC or FQHC. All other providers must bill for these items using the appropriate national drug code (NDC) on the Pharmacy Claim form.

*** The W1 modifier is used when the service is provided in the office, FQHC or RHC.

MC+ FOR KIDS - HEALTH INSURANCE FOR UNINSURED CHILDREN

As a Medicaid provider, you are also an approved provider for the new MC+ for Kids program. All medically necessary services are covered and the program is billed like Missouri Medicaid. Recipient eligibility is available on the ARU or eligibility terminals. Some children reside in an MC+ managed care region and are enrolled with a health plan. Children who do not live in a managed care region receive services on a fee-for-service basis.

MC+ for Kids is a new health insurance program for uninsured children from families who do not qualify for Medicaid, but whose income is below 300% of the federal poverty level. For example, for a family of three making less than $41,640 a year, the child (or children) could be eligible for coverage. An estimated 90,000 uninsured children under the age of 19 qualify for MC+ for Kids.

We are asking providers to help us enroll these children. The simple 2-page application can be obtained by calling 1-888-275-5908. Applications are also available in Spanish and can be downloaded from the Internet at www.dss.state.mo.us.mcplus. All members of one household can be listed on one application. Applications are processed within 30 days.

If you know, or come in contact with, families that need health insurance for their children, please share this information and toll-free telephone number. If you would like to assist in the enrollment effort, applications, posters, and other information are available from the Department of Social Services, Office of Communications at 573-751-3770, fax 573-751-4997 or E-Mail at mhonse@mail.state.mo.us.

CROSSOVER CLAIMS FOR RAILROAD BENEFICIARIES

Part B Medicare claims for Railroad beneficiaries are now processed by United HealthCare.

In the past, Part B Medicare deductible and coinsurance claims for railroad beneficiaries have not been forwarded to Medicaid for processing. Providers were required to submit paper claims using a Part B sticker.

Claims for the deductible and coinsurance portion can now be electronically crossed over to Missouri Medicaid for processing when the individual is eligible for Missouri Medicaid or MC+.
Some crossover claims cannot be processed electronically. Review the following for reasons that claims do not cross over electronically.

- The provider did not indicate on his claim to United HealthCare that the beneficiary was eligible for Missouri Medicaid.

- The recipient information on the crossover claim does not match the fiscal agent's recipient file.

- The provider's Medicare ID number is not on file in the Division of Medical Services' provider files. The provider must notify DMS provider enrollment unit of their Medicare ID number. Because DMS did not accept electronic RR beneficiary crossovers previously, the provider file does not contain the Medicare RRB carrier number. In order for the RR beneficiary claim to crossover, the provider must submit the following information to the Provider Enrollment Unit (PEU).

  1) documentation of their United HealthCare Part B provider number (RA or approval letter)

  2) Medicaid provider number, and

  3) Medicaid provider name

Crossover claims that cannot be processed in the usual manner must be paper-filed.